

FORM PECD 2**WORKER'S COMP INFORMATION SHEET
TO BE COMPLETED BY EMPLOYER ON EACH WORKERS COMPENSATION CLAIM
INFORMATION REQUESTED BY PUBLIC EMPLOYEE CLAIMS DIVISION****5/2001**

- 1) Employer _____
- 2) Employee's Name _____
- 3) Injury Date ____ / ____ / ____ Date Disability Began ____ / ____ / ____
- 4) Has employee returned to work? _____ If so, date ____ / ____ / ____
- 5) Who selected the initial physician or clinic? ☐ Employer ☐ Employee
- 6) Did employee's salary continue while off work?
If so, check source and indicate time period _____
- ☐ Sick Form ____ / ____ / ____ Through ____ / ____ / ____
- ☐ Annual From ____ / ____ / ____ Through ____ / ____ / ____
- ☐ Other From ____ / ____ / ____ Through ____ / ____ / ____
- Employer claim recommendation: Accept ____ - or - Deny ____
- 7) If recommendation is to deny, explain and attach extra page if needed:

- 8) Other employees injured in this accident _____
- 9) Checklist: First report of injury or illness (Form IA-I)
- Employer Name & Address (Upper Left Hand Corner) ☐
- Wage Information ☐ Date of Hire ☐
- Date Disability Began ☐ Return to Work Force ☐
- Contact Name/Phone Number (Whom we should call if we have questions) ☐
- Specific activity & work process employee was engaged in when accident occurred. ☐
- Witness (or person having immediate knowledge) ☐
- Date prepared/signature/phone number ☐
- Attach notes & bills from medical providers if available ☐
- Attach Form W or Computer Printout of employee's wage history for 52 weeks prior to the date of injury ☐
- 10) Have employee complete AR-N and refer to notices on the reverse side of the form. ☐

Name: _____ Title: _____

Phone: _____ Fax: _____ Date: _____